THE CONFEDERATED TRIBES OF THE WARM SPRINGS RESERVATION OF OREGON

2024 Employee Benefit Open Enrollment

AGENDA

- Introductions
- Overview of Benefits
  - Health Benefits - HealthComp
  - Flexible Spending Accounts – Allegiance
  - Life & Disability – Hartford
- Managed Care Discussion

MEDICAL BENEFITS

MEDICAL BENEFITS SCHEDULE

COVERED CHARGES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
DEDUCTIBLE, PER CALENDAR YEAR - Network and Non-Network Deductibles are combined.		
Individual Coverage	$750	$750
Family Coverage	$2,250	$2,250
MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR - Network and Non-Network Out-of-Pocket amounts are combined. Medical and Prescription amounts are separate.		
Individual Coverage	$2,000	$2,000
Family Coverage	$6,000	$6,000
The Plan will pay the designated percentage of Covered Charges until out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Calendar Year unless stated otherwise.		
Percentage Payable – unless otherwise stated.	80% after deductible	80% after deductible

The Tribes will pay 60% of allowable charges up to a maximum limit of $2,500 for those employees and/or their dependents that are eligible for Managed Care Services.

Please refer to the Summary Plan Document for specific benefit information.

PRESCRIPTION BENEFITS

PRESCRIPTION DRUG BENEFIT		
MAXIMUM OUT-OF-POCKET AMOUNT PER CALENDAR YEAR		
	NETWORK	**NON-NETWORK**
Individual Coverage	$5,600	N/A
Family Coverage	$10,200	N/A
Pharmacy Option (30 Day Supply)		
Generic Drugs	$10 or 20%, whichever is the greater copayment	Contact the Prescription Drug Administrator for information regarding non-participating pharmacy benefits or benefits at a participating parmacy when the Covered Person's I.D. care is not used.
Formulary Brand Name Drugs	$30 or 20%, whichever is the greater copayment	
Non-Formulary Brand Name Drugs	$50 or 20%, whichever is the greater copayment	
Specialty Drugs	Not Covered	Not Covered
Mail Order Option (90 Day Supply)		
Generic Drugs	$10 or 20%, whichever is the greater copayment	Not Applicable
Formulary Brand Name Drugs	$25 or 20%, whichever is the greater copayment	Not Applicable
Non-Formulary Brand Name Drugs	$40 or 20%, whichever is the greater copayment	Not Applicable
Specialty Drugs	Not Covered	Not Covered
Refer to the Prescription Drug Section for details on the Prescription Drug benefit.		

DENTAL BENEFITS

DENTAL CARE BENEFIT	
DENTAL CARE DEDUCTIBLE, PER CALENDAR YEAR	
Self Only Coverage	$50
Family Coverage	$150
Calendar Year Deductible applies to these classes of services: Class B Services – Basic, and Class C Services - Major	
MAXIMUM BENEFIT AMOUNT	**BENEFIT**
For Class A - Preventive, Class B - Basic and Class C - Major Services Per Covered Person per Calendar Year- applies to dependents over 19 years of age. The maximum is not included in the $2,500 Managed Care limit.	$2,000
COVERED CHARGES	
Dental Percentage Payable Class A Services - Preventive Class B Services - Basic Class C Services - Major	 100% 80% 50%
Note: No benefits are payable for Class C Services in the first 12 months of the Covered Person's coverage under the Plan.	

VISION BENEFITS

VISION CARE BENEFIT SCHEDULE

COVERED CHARGES	BENEFIT
Exam, lenses, contacts and frames – $400 allowance for persons age 19 and over every 2 Calendar years. $400 allowance every Calendar year for persons under age 19. Maximum amount does not apply to vision exam for dependents under age 19.	100%

Vision benefits are not included in the $2,500 Managed Care program limit.

CIGNA NETWORK

HealthComp

Your network has changed to Cigna - what does this mean?

Frequently Asked Questions:

Q: When my doctor asks who my insurance is through, what should I say?
A: Your medical plan is provided through HealthComp, and you have access to the Cigna PPO Network.

Q: Why does my medical ID Card say to send my claims to Cigna but to call HealthComp for claims questions?

A: As your PPO network provider, Cigna is involved in repricing your medical claims. Repricing means a discount is applied when you utilize a provider that is contracted in the Cigna PPO network. The claim is repriced first before it is sent to HealthComp to process for payment.

Q: Is it ok if my doctor calls Cigna instead of HealthComp to verify benefits?

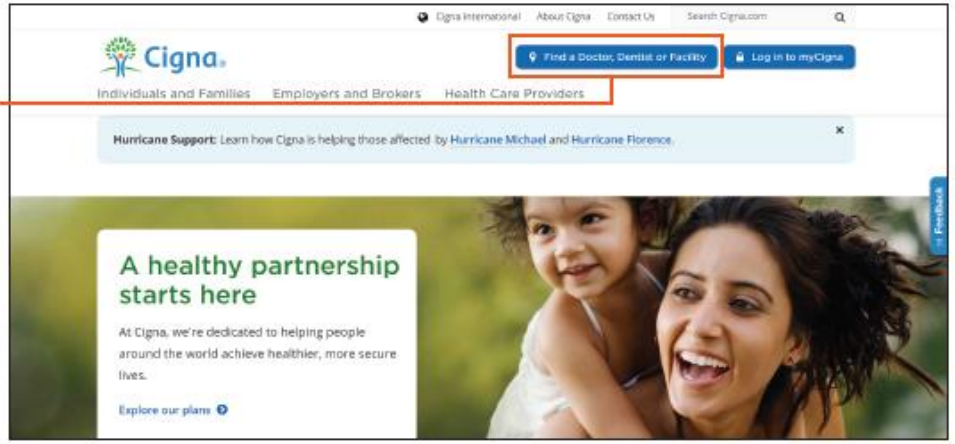
A: No, Cigna does not have any information about your benefits. If your provider calls Cigna, they will be told you don't have insurance. You need to give your provider the information on your HealthComp Medical ID card.

Q: Who can verify eligibility or answer questions about my medical plan?

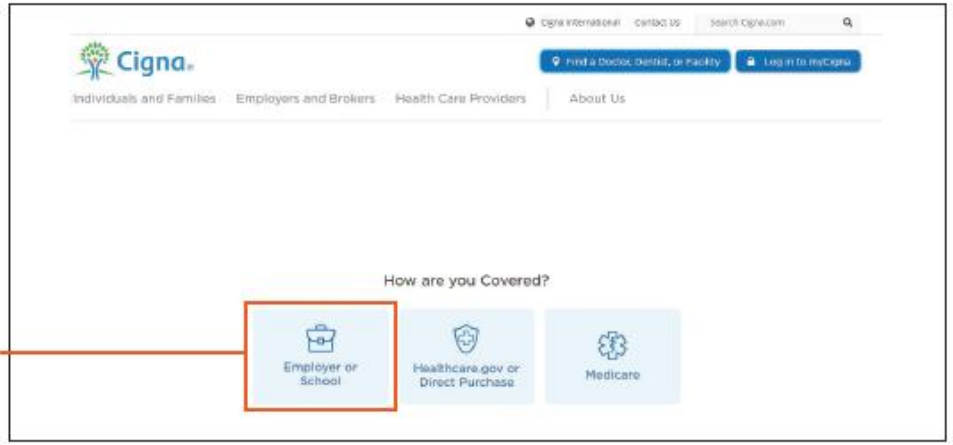
A: HealthComp is your medical administrator and can answer questions about your medical claims, and eligibility.

CIGNA – FIND A PROVIDER

1. Go to **Cigna.com** and click "Find a Doctor, Dentist or Facility."



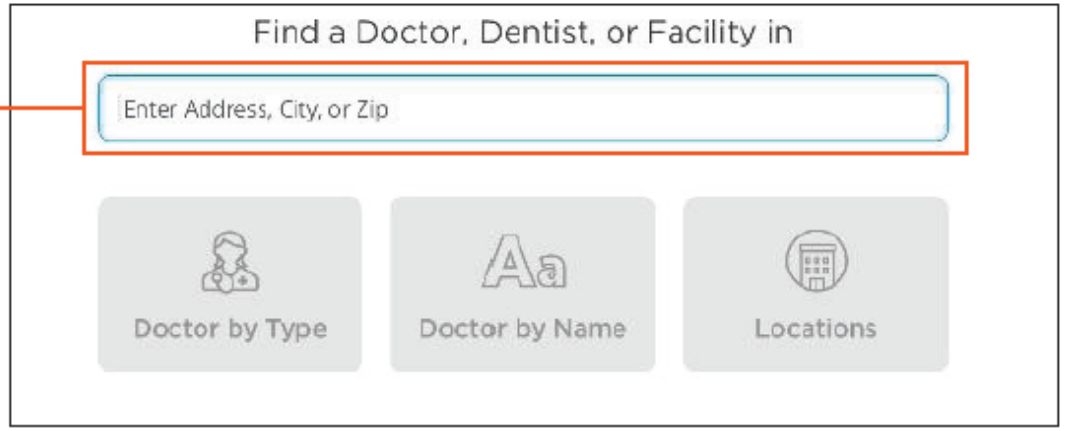
2. On the "How are you Covered" page, select "Employer or School"



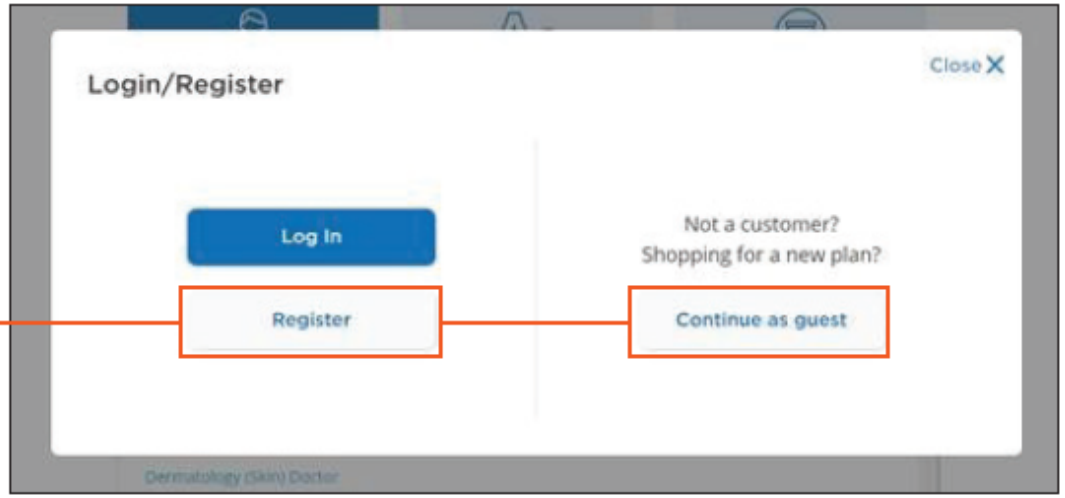
CIGNA – FIND A PROVIDER

HealthComp

3. Enter the geographic location you want to search and select the search type.



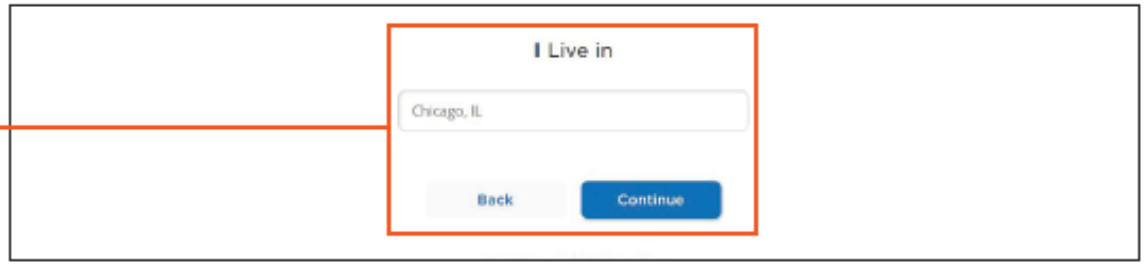
4. Members will then be prompted to either Login/Register for **myCigna.com**, or "Continue as guest."



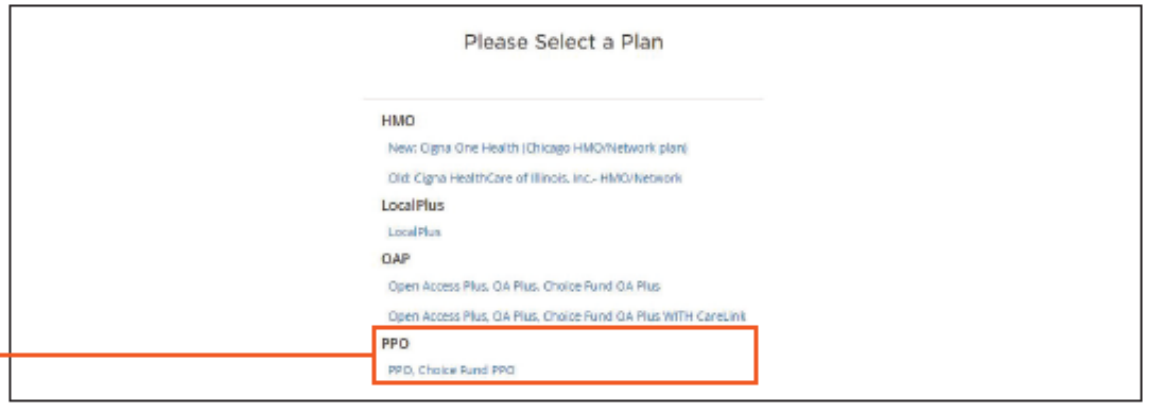
CIGNA – FIND A PROVIDER

HealthComp

5. Fill in the "I Live in" field and click "Continue."



6. Under "Please Select a Plan," Select PPO. (Note: the network name may appear differently in different geographical areas.)



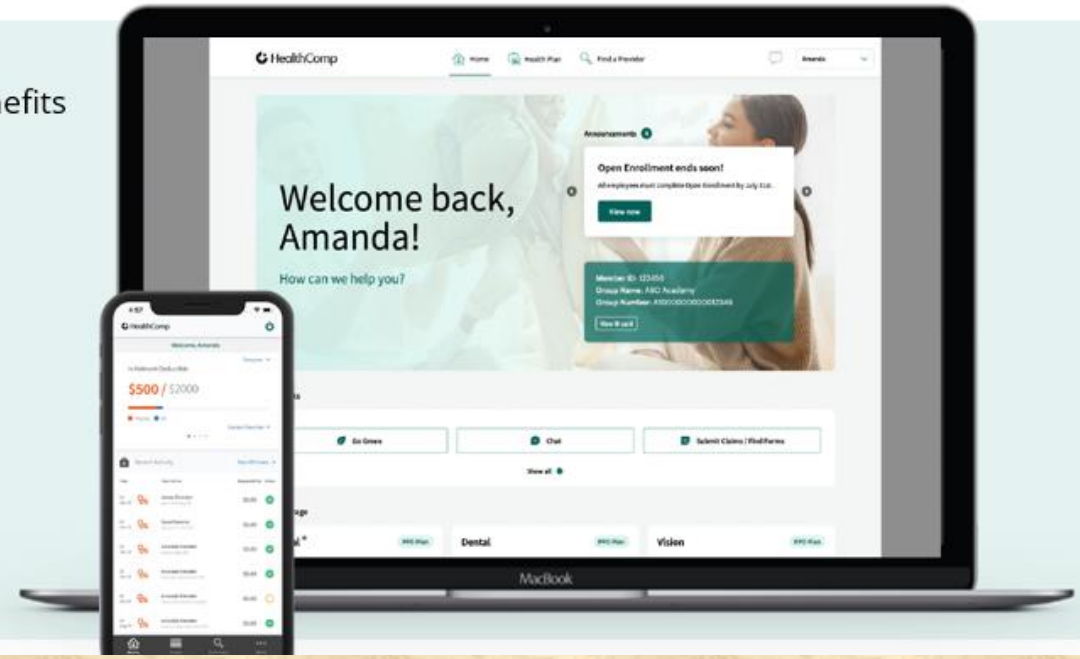
Questions?
Call the toll-free number on the back of your ID card.

HEALTHCOMP

HCOnline: HealthComp at your fingertips

- Access your health and wellness related benefits
- Reduce clutter. Access your digital ID cards
- Find providers
- Review your health-related claims
- Check your plan status
- Understand your coverage
- Chat with a designated Member Advocate

Download the app!



HEALTHCOMP

Connecting with HealthComp is easy

MEMBER ADVOCATE

Call HealthComp and you'll be connected with a **Member Advocate** who can answer your questions quickly.

SELF-SERVICE THROUGH HCONLINE

On our HCOnline member platform, you can access digital ID cards for you and your family, view claims, find care, and more. Access **HCOnline** on desktop or through our mobile app.

Have questions? Ask your Member Advocates.

800-442-7247

ICM CASE MANAGEMENT

Innovative Care Management

Case Management Program

Case Management is a nursing support program for members with complex medical conditions offering:

- Opportunity to talk to compassionate and supportive nurses.
- Access to educational materials.
- Help with understanding your medical condition and staying healthy throughout your treatment.
- Assistance with understanding and navigating insurance.

Examples of conditions we commonly help members with:

- Cancer
- Stroke
- Trauma injuries from major accidents
- Organ failure (transplant)
- High-risk pregnancy

This program is a special benefit of your healthcare coverage and is provided by your health plan at no cost to you.

Contact Us:
Nurse@innovativecare.com
800-862-3338

ICM DISEASE MANAGEMENT

Innovative Care Management

Disease Management Program

Disease Management is an educational program offering:

- Confidence in understanding the steps needed to improve your health.
- Reduced risk of developing certain diseases.
- Less risk of costly healthcare and hospitalizations.
- Lower chances of complications.
- Nurses available to help and support you lead a longer and happier life.
- Customized educational packets every four months.

Conditions we help members manage:

- Asthma
- Chronic Obstructive Pulmonary Disease
- Congestive Heart Failure
- Coronary Heart Disease
- Diabetes (Types 1 and 2)

This program is a special benefit of your healthcare coverage and is provided by your health plan at no cost to you.

Contact Us:
Wellness@innovativecare.com
800-862-3338

ICM HEALTHY MOTHER BABY

Innovative Care Management

Healthy Mother Baby Program

Healthy Mother Baby is a prenatal support program offering:

- Access to a knowledgeable and compassionate nurse specialist to answer questions, provide emotional support and offer education through monthly contact.
- Early screenings to determine and mitigate risks where possible.
- Counseling and pregnancy education.
- Customized educational materials and access to a free resource library.
- Highly rated book on pregnancy and childbirth.
- Follow-up contact regarding breastfeeding and infant care.

This program is a special benefit of your healthcare coverage and is provided by your health plan at no cost to you.

Contact Us:
HMB@innovativecare.com
800-862-3338

FLEXIBLE SPENDING ACCOUNTS

Benefits of Flexible Spending Accounts

- Flexible Spending Accounts allows you to put pre-tax dollars into an account and spend those funds tax-free for eligible medical, dental, vision and childcare daycare expenses
- Your elections are taken through payroll deduction from your salary on a pre-tax basis
- You are NEVER taxed on the money held out of your wages pre-tax
- You can use your funds for any family member (spouse and/or children)
- Plan Options
  - Medical Spending Account
  - Dependent Care Account

FLEXIBLE SPENDING ACCOUNTS

Medical Spending Account

-Plan Year – 01/01 – 12/31
-Covers Medical/Dental/Vision
    -Co-pays/deductibles/coinsurance
    -RX/x-rays/lab/alternative care
    -Fillings/extractions/root canals
    -Crowns/bridges/orthodontia
    -Eye exam/hardware/contacts/Lasik
-Contribute up to $3,200 per plan year
-Covers expenses for entire family
-Contributions deducted over entire plan year
-Entire election available anytime during year
-2 ½ Month Grace Period (2023 plan year extended additional 75 days thru 3/15/2024)
-Run-Out Period of 90 days (06/13)

Dependent Care Account

- Plan Year – 01/01 – 12/31
- Covers child care expenses necessary for employment
- Both parents must be either actively employed or a full time student
- Children must be 12 years of age or less
- Contribute up to $5,000 per plan year

Eligible Providers
-Licensed Day Care Center
-Nanny
-Private party (neighbor/relative – rules apply)
-School
-Contributions deducted over entire plan year

- Reimbursement limited to amount contributed
- 2 ½ Month Grace Period (2023 plan year extended additional 75 days thru 3/15/2024)
- Run-Out Period of 90 days (06/13)

FLEXIBLE SPENDING ACCOUNTS

Over-the-Counter Eligible Expenses

OTC drugs and medicine expenses no longer need a prescription!

Allergy & sinus medicine
Antibiotics
Pain relievers
Acid controllers
Cough, cold & flu medicines
Anti-itch & insect bite

Insulin
Blood sugar monitors
Contact lens solution
Bandages
Crutches
Denture bond

Please keep this in mind when making flex elections during open enrollment

FLEXIBLE SPENDING ACCOUNTS

How to Access Your Funds

- You must **incur** an expense before you can be reimbursed
- Reimbursement Options
  - Debit Card
  - File claim online
  - File claim using mobile app
  - Fax or mail (this method takes longer to get reimbursed)
- You must include proof of what you owe
  - Explanation of Benefits (EOB)
  - Co-pay receipt
  - Itemized statement from provider
  - All documentation must include date of service and amount owed

BASIC LIFE AND AD&D

Confederated Tribes of Warm Springs provides all eligible employees with a Basic life insurance benefit for yourself and your eligible dependents, at no cost to you.

COVERAGE INFORMATION

APPLICANT	LIFE COVERAGE	AD&D COVERAGE
Employee	Benefit[2]: 2 times earnings Maximum: $350,000	AD&D: Included
Spouse	Benefit[2]: $1,000	AD&D: Not included
Child(ren)	Benefit: $1,000	AD&D: Not Included

VOLUNTARY LIFE AND AD&D

If you want to increase the amount of life insurance and AD&D that you have, you can elect supplemental coverage that you pay for with payroll deductions. Premium amounts are based on age, gender and tobacco usage status for life, and tobacco usage status for AD&D.

COVERAGE INFORMATION

APPLICANT	LIFE COVERAGE	AD&D COVERAGE
Employee	Benefit[2]: Increments of $10,000 Maximum: the lesser of 5x earnings or $500,000	AD&D: Included
Spouse	Benefit[2]: Increments of $10,000. Maximum: the lesser of 100% of your supplemental coverage or $500,000	AD&D: Included
Child(ren)	Benefit: Increments of $2,000 Maximum: $10,000	AD&D: Included

EMPLOYER PAID SHORT TERM DISABILITY

Short-Term Disability	**1st of the month following 90 days.** **(you must apply for benefits)**	Provides income replacement if you have an eligible illness or injury off the job. You would receive 60% of your pre-disability earnings or $200 per week whichever is lesser. **All of the employee sick leave must be used before the short-term disability begins.**

VOLUNTARY SHORT TERM DISABILITY

You have the option of electing Short Term Disability coverage. If you elect this you will pay the premiums by payroll deduction. Premium amounts are based on your age.

COVERAGE INFORMATION

BENEFIT PERCENTAGE (PERCENT OF YOUR EARNINGS)	MAXIMUM	MINIMUM	SICKNESS BENEFIT STARTS	INJURY BENEFIT STARTS	BENEFIT DURATION
60%	$1,000	$25	On the 15th day	On the 15th day	11 weeks

VOLUNTARY ACCIDENT

Voluntary Accident coverage is also available to you, paid for via payroll deduction. This benefit provides a cash benefit to you for various accidents and injuries that may be incurred.

PREMIUMS

The amounts shown are monthly amounts (12 payments/deductions per year):[4]

COVERAGE TIER	
Employee Only	**$6.88** ($0.23 per day)
Employee & Spouse	**$10.82** ($0.36 per day)
Employee & Child(ren)	**$11.42** ($0.38 per day)
Employee & Family	**$18.00** ($0.59 per day)

VOLUNTARY CRITICAL ILLNESS

Similar to Accident coverage, Critical Illness coverage supplies a cash benefit when diagnosed with various illnesses. Like all the voluntary products, it is paid for via payroll deduction. The rates are based on age, gender and tobacco usage status.

COVERAGE ELECTION & AMOUNT(S)	
In order to be insured under the Policy an Employee must elect coverage for themself and any Dependent(s). The Employee is required to pay premium for the coverage elected. Payment of premium does not guarantee eligibility for coverage. Any amount of insurance for a Spouse/Partner or Dependent Child(ren) will be rounded to the next higher multiple of $1,000, if not already an even multiple of $1,000. All Coverage Amount(s) are Guaranteed Issue.	
Employee	Choice of $5,000 to $20,000 in increments of $5,000
Spouse/Partner	50% of the Employee's elected Coverage Amount
Dependent Child(ren)	50% of the Employee's elected Coverage Amount (per child)

EMPLOYEE ASSISTANCE PROGRAM

THE HARTFORD

EXTRAS THAT SUPPORT AND ASSIST

For access over the phone, simply call toll-free

800-96-HELPS
(800-964-3577)

Visit guidanceresources.com to access hundreds of personal health topics and resources for child care, elder care, attorneys or financial planners.

If you're a first-time user, click on the Register tab.

1. In the Organization Web ID field, enter: HLF902
2. In the Company Name field at the bottom of personalization page enter: ABILI
3. After selecting "Ability Assist program", create your own confidential user name and password.

Snap a photo with a mobile device to capture information above.

For employees covered under a fully-insured group policy or Leave Management services with The Hartford.

Life presents complex challenges. If the unexpected happens, you should have simple solutions to help cope with the stress and life changes that may result. That's why The Hartford Ability Assist® Counseling Services, offered by ComPsych®,[1] can play such an important role. Our straightforward approach takes the complexity out of benefits when life throws you a curve.

COMPASSIONATE SOLUTIONS FOR COMMON CHALLENGES

From everyday issues like job pressures, relationships and retirement planning to highly impactful issues like grief, loss, or a disability, Ability Assist is your resource for professional support.

You and your family, including spouse and dependents can access Ability Assist at any time, as long as you are covered under a fully-insured group policy or Leave Management services with The Hartford.

SERVICE FEATURES

The service includes up to three face-to-face emotional counseling sessions per occurrence per year. This means you and your family members won't have to share visits. You can each get counseling help for your own unique needs. Work-life services and counseling for your legal, financial, medical and benefit-related concerns are also available by phone.

The EAP is provided at no cost to you.

MANAGED CARE DISCUSSION

CTWS Managed Care Program

Also known as, Purchased & Referred Care (PRC)

Contract Health Services (CHS)

MANAGED CARE DISCUSSION

OVERVIEW OF THE MANAGED CARE PROGRAM

- The MCP is managed by the CTWS. Prior to October 1993, it was operated by I H S & was referred to as Contract Health Services.
- MCP provides payment of health care referrals that are outside of the WS Health & Wellness Center, and these referrals can only be authorized by the MCP.
- Authorization of these referrals are based on Medical category guidelines & eligibility criteria.

Short version: MCP covers the cost for all referred care, Specialty Clinics, Emergency Room Visits & patient health care needs that are deemed "Medically Necessary", for all MCP eligible patients.

MANAGED CARE DISCUSSION

Who works at Managed Care, and what they do....

- Michael Collins – Director
- Susan Brunoe – Case Manager
- Pasha Smith – Supervisor
- Rhonda Greene – Patient Advocate
- Liana Holyan – Health Systems Data Analyst
- Tatum Kalama – Health Systems Specialist

MANAGED CARE DISCUSSION

How do I know if I or my dependents are eligible with MCP?

- Must have an active Chart @ WS clinic.
- WS Tribal Members, for MCP eligibility a members physical residence is on the WS Reservation, or live in one of these counties (Jefferson, Wasco, Linn, Clackamas & Marion)
- Members of OTHER Federally Recognized Tribe, these members must live on the Warm Springs Reservation, to maintain MCP eligibility.
- It is the Members responsibility to always update their Physical address & mailing address, with WS clinic to maintain the most current information.
- Inaccurate or incomplete information could affect eligibility for MCP.
- Members must utilize WS clinic as their primary care, a WS provider should be your primary provider.

MANAGED CARE DISCUSSION

MCP Referral Process

IHS Referral

- Patient has an appointment with IHS provider
- IHS provider referred patient
- Referral is "received" in MCP office by Health Systems Specialist & reviewed for eligibility & alternate resources
- Referral is Forwarded to MCP Case Manager, for approval
- Approved referrals are faxed depending on the category of all individual referrals. Category I & II are faxed the someday referral is generated. Category III & IV held for 24 hours and faxed the next business day
- Patients should always check in with MCP to ensure their referral has been authorized by MCP

Other types of Referrals

- Patient utilizes the ER & is referred out from the Emergency Room.
- **1.**Patient should notify MCP within 72 hours of that ER visit **2.** Always follow up with your primary provider @ IHS after ER visits **3.**Patient needs to notify MCP that they were referred out to a specialty provider from the ER.
- Patient is at their appointment for an approved IHS referral & referred from that outside appointment to another department, Patient should always notify MCP of those situations. Otherwise it's seen as a patient self referral, and could be denied

MANAGED CARE DISCUSSION

Specialty clinics

- ENT & Audiology
- Oral Surgeon & Endodontist
- Physical Therapy & Acupuncture
- OBGYN & Neonatal
- Ultrasound
- Rheumatology
- Behavioral Health Services

Because WSMCP has contracted with providers to service our community for the NEED for these specialties, MCP does not approve referrals for members who elect to see other providers for these specialties.

MANAGED CARE DISCUSSION

ALTERNATE RESOURCES

Q: Why MCP sends letter asking Members to apply for OHP, Work Comp, Auto ins or provide my Medicare Card or Private ins card.

Examples of Alternate Resources:

- Medicare (part A and or part B)
- Medicaid, Oregon Health Plan (OHP)
- Private Insurance
- Children's Rehabilitative Services
- Auto Insurance
- Work Compensation
- State Vocational Rehabilitation
- State Mental & Child Health Programs
- Veterans Benefits

MANAGED CARE DISCUSSION

ALTERNATE RESOURCES

- Members are required by federal regulation to apply for an alternate resource if there is reason to believe that you may be eligible for alternate resources.
- Once on Medicaid/Oregon Health Plan (OHP), members are required to renewal annually.
- If you have been deemed not eligible for OHP, "over income"; WSMCP will not ask you to apply again, until the following year, on an annual bases.
- If you are referred for a work related injury, you are required to file work comp claim with your employer.
- Auto Accident, you are required to provide Auto Insurance to WSMCP if you are referred for injuries acquired in an auto accident, or you utilize the Emergency department, or hospitalized for injuries due to auto related injuries from an accident.
- If you switched employers, you are required to provide you most current private insurance
- When you are Medicare eligibility, members must provide their Medicare card. Medicare part (A) is free to patients when they reach the age of 65
- If you are get on disability and acquire coverage my Medicare, you are required to provide that to MCP
- Any Alternate resource, that's available and accessible to members at no cost, WSMCP can ask you to apply to see if you qualify.
- If you refuse to apply, renew or refuse to use that alternate resource the MCP will not be responsible for payment of your medical bills.

MANAGED CARE DISCUSSION

Referral & Alternate Resource

- Always keep appointments when referred out
- If you have a referral, but have not received a call to schedule. Stop or call by MCP office. Health Systems Specialist & Data Analyst will give you the Phone # or if you are needing assistance can call to set up appointment.
- If you are not able to keep your appointment, notify the providers office ASAP, to reschedule or cancel your appointment.
- There are providers that charge NO SHOW FEE's, MCP does not pay these for patients.
- Always present your insurance cards & OHP ID
- If you do not know your OHP ID#, call MCP Patient advocate, will assist in providing for you or your dependents with your OHP ID#

MANAGED CARE DISCUSSION

OTHER MANAGED CARE TOPICS

Patient Billing Statements

- Members, before dropping your medical bills off at the MCP office. MCP staff recommend that you call to provide your insurance information.
- There are Provider billing offices that generally will not speak to MCP staff regarding your Patient account.
- If you elect to drop your medical bills off with MCP, please drop of ASAP.
- Medical Bills that are in collections, MCP does not pay collections, and collections representatives will not speak to MCP.
- BEST RULE: Always drop Medical Bills off @ WSMCP ASAP!!

MCP Denials

- If you receive a denial letter from MCP, please read the letter before calling MCP.
- Members have the right to appeal all MCP denials
- Appeals are only accepted in writing.
- Your appeal letter should include your reasoning to why MCP should assist in the payment of your medical bill.
- Appeals are can be sent to MCP Director, Michael Collins.

MANAGED CARE DISCUSSION

MEDICAL BILLS CAN BE FAXED OR EMAILED

Email

- Managedcare@wstribes.org

FAX NUMBER

- 541.553.2476

QUESTIONS?

Questions/Discussion?